

FY 2006 Bills Payment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11201	Perform EDI Oversight	<p>The costs related to the establishment of EDI authorizations, monitoring of performance, and support of EDI trading partners to assure effective operation of EDI processes for electronic billing, remittance advice, eligibility query, claims status query, and other purposes; and/or between Medicare and a bank for electronic funds transfer or remittance advice.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual – Medicare Claims Processing Manual Chapters 22, 24, 25, and 31 CRs amending the IOM: None 	<p>a. Obtaining valid EDI and Electronic Funds Transfer (EFT) agreements, provider authorizations for third party representation for EDI, and network service agreements. Entry of that data into the appropriate provider-specific and security files, and processing reported changes involving those agreements and authorizations</p> <p>b. Issuance, control, updating, and monitoring of system passwords and EDI claim submission/inquiry account numbers to control electronic access to beneficiary and provider data</p> <p>c. Sponsorship of providers and vendors for establishment of connectivity via a private network, virtual private network, or secure dial up connections where supported to enable the electronic exchange of data via DDE, if supported, and EDI</p> <p>d. Systems testing with electronic providers/agents as directed by CMS to assure compatibility between systems for the successful exchange of data</p> <p>e. Submission of EDI data, status reports on the progress of HIPAA transactions implementation, weekly reports on the progress of submitter testing, and other EDI status reports as directed by CMS</p> <p>f. Processing of ASCA exception requests for situations not subject to provider self-assessment, and for which CMS requires contractor evaluation</p> <p>g. Monitoring and analysis of recurring EDI submission and receipt errors, and coordination with the submitters and receivers as necessary to eliminate the identified errors</p> <p>h. Maintenance of a list of software vendors</p>	

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			<p>and clearinghouses whose EDI software has successfully tested for submission of transactions to Medicare</p> <p>i. Provision of customer support for the use of free/low cost billing software, and PC Print software</p> <p>j. Basic support of trading partners in the interpretation of transactions as issued by Medicare</p> <p>k. Marketing of EDI to increase provider usage of the claim status and remittance advice transactions in FY 06</p>	
11202	Manage Paper Bills/Claims	<p>All costs related to the receipt, control, and entry of paper claims (i.e., the UB-92/CMS-1450) and for maintenance of the standard paper remittance advice format. This activity encompasses tasks prior to and following the shared system process.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual - Medicare Claims Processing Manual, Chapters 22, Section 50 and 25.1, Section 50.1 MSP Manual Chapter 3, Section 30 	<p>a. Opening, sorting, and distributing incoming claims including paper adjustment bills</p> <p>b. Assigning control numbers and date of receipt</p> <p>c. Imaging of paper claims and attachments</p> <p>d. Data entry (manual or optical character recognition scanning) of paper claim data, and primary payer data when submitted on paper, and re-entry of data for corrected/developed paper bills</p> <p>e. Identification of paper claims during the data entry process that cannot be processed due to incomplete information</p> <p>f. Resolution of certain front-end edits related to paper claims</p> <p>g. Return of incomplete paper claims, and paper claims that failed front-end edits to submitters for correction and resubmission</p> <p>h. Re-enter corrected/developed paper claims, managing paper bills and paper adjustment bills</p> <p>i. Updating the SPR once per year as directed by CMS to keep corresponding fields in the electronic and paper remittance advice formats in sync</p>	<p>Workload 1 is the difference between the total bills reported on the CMS-1566, Page 11, Line 38, Column 1 minus the EMC bills reported in Line 38, Column 8.</p>

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11203	Manage EDI Bills/Claims	<p>Establish, maintain and operate the infrastructure for EDI and DDE for claims, remittance advice, status query, eligibility query and EFT. Requires 1 upgrade per year in each of the EDI formats supported, free billing software, PC-Print software, and related tasks.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual – Medicare Claims Processing Manual Chapters 22, 24, 25, and 31 Activity related CRs: CR 3685 (Standardization of Group and Reason code usage) CR 3645 (SPR change) CR 3440 (Enforcement of ASCA) CR 3815 (Enforcement of ASCA) New CR (Change in add-on payment reporting in the remittance advice) Companion Documents and Flat Files for 837I, 837P, 835 and 267/277 published at: http://www.cms.hhs.gov/providers/edi/hipaa/doc1.asp 	<p>a. Obtaining free billing and PC-Print software, and upgrading that software once per year, if so directed by CMS</p> <p>b. Maintenance, if applicable, and Alpha testing and validation of free billing software prior to issuance to providers/agents</p> <p>c. Resolution of problems with telecommunication protocols and lines, software and hardware to support connections to enable providers/agents to electronically send/receive data for EDI transactions in a secure manner</p> <p>d. Maintenance of capability for receipt and issuance of transactions via direct data entry (DDE), and via electronic transmission of transactions in batches</p> <p>e. Maintenance of EDI access, syntax and semantic edits at the front-end, prior to shared system processing</p> <p>f. Routing of electronic edit and exception messages, electronic claim acknowledgements, electronic claims development messages, and electronic remittance advice and query response transactions to providers/agents via direct transmission or via deposit to an electronic mailbox for downloading by the trading partners, and routing of electronic funds transfer (EFT)</p> <p>g. Maintenance of back end edits to assure that outgoing electronic remittance advice 835 and 277 response transactions comply with the applicable implementation guide requirements, and that ACH EFT transactions comply with those separate requirements</p> <p>h. Creation and retention of a copy of each</p>	<p>Workload 1 is reported on the CMS-1566, Page 11, Line 38, Column 8.</p>

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			<p>EDI claim and submitted adjusted claims as received and the ability to recreate each 835 and 837 COB transaction as issued</p> <p>i. Maintenance of audit trails to document processing of EDI transactions</p> <p>j. Translation of transaction data between the pre-HIPPA and HIPAA standard formats and the corresponding internal flat files used in the shared system</p> <p>k. Updating of claim status and category codes, claim adjustment reason codes, remittance advice remark codes, and taxonomy codes three times a year per the updating schedule as directed by CMS</p> <p>l. Billing of third parties as directed by CMS for access to beneficiary eligibility data by legacy format, maintaining receivables for those accounts, and terminating third parties if warranted due to non-payment</p>	

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11204	Bills/Claims Determination	Most of the costs related to the determination of whether or not to pay a claim after claim entry and initial field edits are automated and captured under the Run Systems activity. However, operational support staff is required to support claims pricing and payment in conjunction with the programming activities included under Run Systems. Costs of these support activities, which include the creation, maintenance, and oversight of reasonable charge screens, fee schedules, and other pricing determination mechanisms that support claims payment processing systems, are reported under the Claims Determination activity. Also, the cost of any staff intervention in the adjudication of claims resulting from automated claims payment edits should be assigned to this activity.	<ul style="list-style-type: none"> a. Maintain fee schedule (local variations) b. Check for duplicates c. Identify claims that have to be resolved manually d. Re-enter corrected/developed claims (pending) e. Resolve edits on claims that cannot be processed (if possible) f. Maintain pricing software modules g. Update HCPCS, diagnostic codes and other code sets that impact pricing as needed 	Workload 1 for adjudicated bills is the cumulative number of bills processed reported on the CMS-1566, Page 1, Line 12, Column 1.

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11205	Run Systems	The costs of procurements and the programmer/management staff time associated with the systems support of claims processing outside those provided by the standard system maintainer under direct contract to CMS. It also includes, but is not limited to: CPU costs for claims processing (including those associated with the application of MIP edits); validating new software releases; maintaining interfaces and testing data exchanges with standard systems, CWF, HDC, State Medicaid Agencies; maintaining the Print Mail function, on-line systems, telecommunications systems, and mainframe hardware; providing LAN/WAN support; and ongoing costs of transmitting claims data to and from the CWF host, as well as other telecommunications costs.	<ul style="list-style-type: none"> a. Test releases b. Assign Data Center costs c. Purchase software/hardware d. Generate data for MSNs/EOMBs/NOUs, paper remittance advices, and paper checks (Note: any associated printing and mailing costs will be included in the "Manage Outgoing Mail" activity) e. Manage change requests 	
11206	Manage Information Systems Security Program	<p>The costs necessary to adhere to the CMS information systems security policies, procedures and core security requirements, re: the CMS Business Partner Systems Security Manual (BPSSM).</p> <p>Reference:</p> <ul style="list-style-type: none"> • BPSSM Section 2.2 • BPSSM Section 3.1 • BPSSM Section 3.2 • BPSSM Section 3.3 • BPSSM Section 3.4 • BPSSM Section 3.5.1 • BPSSM Section 3.5.2 • BPSSM Section 3.6 • BPSSM Section 3.7 • BPSSM Section 3.8 • BPSSM Appendix A, Section 2 	<ul style="list-style-type: none"> a. Principal Systems Security Officer (PSSO) staffing (including support staff), and training and supporting PSSO functions and responsibilities (Section 2 of the BPSSM) b. Conduct an annual self-assessment using the CMS Integrated Security Suite (CISS) (formerly CAST) (A-2 of the BPSSM) c. Develop, review and update the systems security plans (Section 3.1 of the BPSSM) d. Conduct, review and update the Information System Risk Assessment (Section 3.2 of the BPSSM) e. Prepare the annual systems security component of internal control certification (Section 3.3 of the BPSSM) f. Prepare, review, update and test the information technology systems contingency plan (Section 3.4 of the BPSSM) 	

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			g. Conduct an Annual Compliance Audit and implement Corrective Action Plans to resolve resultant findings (Section 3.5 of the BPSSM) h. Develop Computer Incident Reporting and Response Procedures (Section 3.6 of the BPSSM) i. Develop and maintain a system security profile (Section 3.7 of the BPSSM)	
11207	Perform Coordination of Benefits Activities with the Coordination of Benefits Contractor (COBC), Supplemental Payers, and States	The costs associated with the continuation of activities related to the crossing over of Medicare processed claims data to existing trading partners and costs associated with the transmission of Medicare processed claims to the COBC. Reference: <ul style="list-style-type: none"> Pub. 100-04, Section 70.6, Chapter 28 	a. Maintain and support your existing Trading Partner Agreements (TPAs) during transition to the COBA process, including providing assistance to the trading partner as it cancels its TPA and coordinates its COBA implementation to avoid loss of crossed claims b. Coordinate with the COBC to ensure that 837 flat file transmission issues, including transmission problems, data quality problems, and other technical difficulties, are resolved timely c. Provide to Financial Management the COBA claim data transferred to the COBC and received on error reports from the COBC for reporting and reconciliation purposes d. Upon issuance of a CMS program transmittal, coordinate with the COBC to ensure that trading partner requests for retrospective claims (COBA recovery process) are processed timely	Workload 1 is the number of claims transferred to existing trading partners under current TPAs (IER and FACP reporting). Workload 2 is the number of claims transferred to the COBC under COBAs (IER and FACP reporting).
11208	Conduct Quality Assurance	The costs related to routine quality control techniques used to assure the effectiveness and accuracy of claims processing, quality assurance reviews of fee schedules, HCPCS and ICD-9 updates and maintenance; and review of contractor systems.	a. Review suspended/reopened claims for correct processing b. Review processed paper/EMC claims for accuracy c. Perform other QC sampling techniques for claims processing d. Perform QA on fee schedules maintenance	

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			and contractor systems	
11209	Manage Outgoing Mail	<p>The costs to manage the outgoing mail operations for the bills/claims processing function (e.g., costs for postage, printing NOUs/MSNs/EOMBs, remittance advices and checks, and paper stock).</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Claims Processing Manual, Chap.1, Section 20 Medicare Claims Processing Manual Chap. 22, Section 10 	<p>a. Mail NOUs/MSNs/ EOMBs, paper remittance advices, and checks</p> <p>b. Mail requests for information (other than medical records or MSP) to complete claims adjudication</p> <p>c. Return unprocessable claims to providers</p> <p>d. Return misdirected claims</p> <p>e. Forward misdirected mail</p>	
11210	Reopen Bills/Claims	<p>The costs related to the post-adjudicative reevaluation of an initial or revised claim determination in response to (e.g.) the addition of new and material evidence not readily available at the time of determination; the determination of fraud; the identification of a math or computational error, inaccurate coding, input error, or the misapplication of reasonable charge profiles and screens, etc. <i>(Note: Include the cost of processing an adjustment, but only if the adjustment is specifically related to a reopening. Do not include the cost of an adjustment to a claim that results from an appeal decision).</i></p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual-Publication 100-4, Chapter 29, Section 90 	<p>a. Receive written inquiry or referral for reopening</p> <p>b. Control and image claim</p> <p>c. Research validity of issues related to the reopening</p> <p>d. Adjust claim as appropriate</p> <p>e. Issue response related to claims determination if necessary (e.g., a revised NOU or EOMB)</p> <p>f. Refer to other areas if appropriate to the circumstances</p> <p>g. Document and maintain files for appropriate retrieval</p>	

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12110	Part A Redeterminations	<p>All costs and workloads associated with conducting the Redetermination.</p> <p>Reference:</p> <ul style="list-style-type: none"> • §1869 and §1816(f)(2)(A)(i) of the Act • 42 CFR §405.710-405.717 • Medicare Claims Processing Manual, Chap. 29, Section 40.2, 40.3, 40.4 • Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 • Sections 933 and 940 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 • CR 2620 • CR 3530 	<p>a. Receive redetermination request in corporate mailroom and date stamp</p> <p>b. Assign contractor control number (CCN) to request</p> <p>c. Scan redetermination request and other documentation as necessary</p> <p>d. Forward request to appropriate department</p> <p>e. Begin redetermination case preparation, validate the request</p> <p>f. Enter data as necessary into system/database</p> <p>g. Write and mail a redetermination dismissal letter, if necessary, or</p> <p>h. Write and mail a redetermination acknowledgement letter</p> <p>i. Obtain consultant/RN/specialist opinion as necessary</p> <p>j. Write or call appellant to request additional documentation as necessary</p> <p>k. Make a determination about the redetermination request</p> <p>l. Write and mail a redetermination determination letter to appellant and cc: other parties</p> <p>m. Request and receive written assurance from provider that payment has not been made prior to the decision</p> <p>n. If decision is partially or wholly reversed, effectuate decision and close case</p> <p>o. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible ALJ request for redetermination decisions issued before May 1, 2005. For redetermination decisions issued on or after May 1 2005, the case should be maintained and stored for possible forwarding to the QIC.</p>	<p>Workload 1 Redetermination Requests Cleared (claims) (CMS-2591, Line 7, Column 1)</p> <p>Workload 2 Redetermination Requests Cleared (cases) (CMS-2591, Line 6, Column 1)</p> <p>Workload 3 Redetermination Requests Reversed (cases) (CMS-2591, Line 11, Column 1)</p>
12120	Part A ALJ Hearing Requests and Effectuations, and DAB Referrals, Requests for Case Files, and Effectuations	<p>All costs and workloads associated with processing ALJ hearings, including receiving requests, preparing case files, and effectuating ALJ decisions for redeterminations issued before May 1, 2005.</p> <p>For redeterminations issued on or after May 1, 2005, the QIC is responsible for accepting ALJ requests and preparing case files for the hearing.</p> <p>All costs associated with processing</p>	<p>For Part A ALJ requests and effectuations:</p> <p>a. Receive ALJ hearing request or request for case file from ALJ office in corporate mailroom and date stamp it</p> <p>b. Assign a CCN to ALJ hearing request or case file request</p> <p>c. Scan ALJ hearing request and any other documentation, if applicable</p> <p>d. Forward ALJ hearing request or case file request to the appropriate department</p> <p>e. Enter data as necessary into system/database</p> <p>f. Assemble ALJ hearing case file and make and maintain an exact copy</p> <p>g. Forward ALJ hearing case file to OMHA</p>	<p>Workload 1 Part A ALJ Hearing Requests Forwarded (claims) (CMS-2591, Line 57, Column 1)</p> <p>Workload 2 Part A ALJ Hearing Requests Forwarded (cases) (CMS-2591, Line 56, Column 1)</p> <p>Workload 3 Part A</p>

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		<p>DAB referrals, DAB requests and DAB effectuations.</p> <p>Reference:</p> <p>Part A ALJ requests and effectuations:</p> <ul style="list-style-type: none"> • §1869 and §1816(f)(2)(A)(ii) of the Social Security Act • 42 CFR §405.720-405.722 • Medicare Claims Processing Manual, Chap. 29, Section 40.5, 40.6, 40.7, 50.7AB-03-133 • Part A DAB referrals, requests for case files, and effectuations: • 42 CFR §405.724 • Medicare Claims Processing Manual, Chapter 29, Section 40.7, 50.7, 60.5 CR 3530 • Joint Signature Memo 05306 <p>Misc. Code: 12120/01 – Courier Service Fee – For redeterminations issued before May 1, 2005, all costs of using a courier service to forward requests for Part A ALJ hearing and case files.</p> <ul style="list-style-type: none"> • Medicare Claims Processing Manual, Chap. 29, Section 60.19.4; • CR 3530 <p>ALJ case files forwarded on or after June 30, 2005 will be processed by HHS ALJs. The DAB referral process for these cases will no longer be the responsibility of the contractor.</p>	<p>h. Receive and control ALJ hearing file and decision</p> <p>i. Review ALJ decision, if issued by SSA ALJ</p> <p>j. Request and receive written assurance from provider that payment has not been made prior to ALJ decision (if whole or partial reversal)</p> <p>k. Compute the amount due to the appellant/party based on the ALJ decision (if whole or partial reversal)</p> <p>l. Enter data as necessary into system/database</p> <p>m. If no referral, effectuate ALJ decision</p> <p>n. Place documentation confirming payment has been made in case file, if applicable</p> <p>o. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals</p> <p>For redeterminations issued on or after May 1, 2005,</p> <ol style="list-style-type: none"> a. effectuate action only in response to formal decision. b. Obtain written assurance from provider, as needed c. Calculate payment, in accordance with CR 3530 d. Notify AdQIC within 14 days of effectuation <p>For Part A DAB referrals, requests for case files, and effectuations (from SSA ALJs – HHA ALJ referrals will be handled by the QIC):</p> <ol style="list-style-type: none"> a. Prepare draft Agency Referral memo and case file, and forward to lead RO or b. Receive and control the appellant's DAB review request or the DAB's request for a case file c. Retrieve case file d. Copy any additional correspondence and make a copy of the original case file and maintain e. Send original case file to the DAB f. Effectuate DAB's decision g. Enter case status information throughout the process of this activity and update as necessary 	<p>ALJ Hearings Effectuated (cases) (CMS-2591, Line 72, Column 1)</p>

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12142	Part B Written Redeterminations	<p>All costs and workloads associated with completing a written redetermination. Written redeterminations are those reviews that are requested in writing and subsequently completed in writing.</p> <p>Reference:</p> <ul style="list-style-type: none"> • §1869 and §1842(b)(2)(B)(i) of the Social Security Act • 42 CFR 405.807 – 405.812 • Medicare Claims Processing Manual, Chap. 29, Section 50.3 • Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000; • Sections 933 and 940 of the Medicare Prescription Drug, Improvement and Modernization Act 2003 • CR 2620 • CR 3530 <p>Misc. Code: 12142/01 – Dismissals/Withdrawals of Written Redeterminations – All costs associated with processing written redeterminations that are dismissed or withdrawn. Include incomplete redetermination requests received on or after May 1, 2005.</p>	<p>a. Receive written redetermination request in corporate mailroom and date stamp request</p> <p>b. Assign CCN to review request</p> <p>c. Scan redetermination request and any other documentation, if applicable</p> <p>d. Forward redetermination request to appropriate department</p> <p>e. Begin case preparation and validate request</p> <p>f. Enter data as necessary into system/database</p> <p>g. Evaluate evidence and case history of redetermination request</p> <p>h. Obtain consultant/RN/specialist opinion for redetermination request, if necessary</p> <p>i. Write or call appellant to request additional documentation for the redetermination, if necessary</p> <p>j. Receive, scan and control additional documentation for redetermination, if necessary</p> <p>k. Make a determination about the redetermination request</p> <p>l. Write a redetermination decision letter</p> <p>m. If beneficiary initiated, write a decision letter at appropriate reading level</p> <p>n. Issue an EOMB/MSN/RA</p> <p>o. Mail redetermination determination letter to parties, if applicable</p> <p>p. If decision is partially or wholly reversed, effectuate decision</p> <p>q. For redeterminations issued before May 1, 2005, enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible HO Hearing Request. For reterminations issued on or after May 1, 2005, store and maintain case file for possible forwarding to the QIC.</p>	<p>Workload 1 Written Redetermination Requests Cleared (claims) (CMS-2591, Line 7, Column 5)</p> <p>Workload 2 Written Redetermination Requests Cleared (cases) (CMS-2591, Line 6, Column 5)</p> <p>Workload 3 Written Redeterminaiton Request Reversals (cases) (CMS-2591, Line 11, Column 5)</p> <p>Misc. Code Written Redetermination Requests Dismissed or Withdrawn (cases) (CMS-2591 Line 10, Column 5)</p>
12150	Part B Hearing Officer Hearings	<p>All costs and workloads associated with processing, and conducting on-the-record, telephone, and in-person Hearing Officer (HO) Hearings.</p> <p>All costs and workloads associated with processing a dismissal/withdrawal of a</p>	<p>a. Receive HO hearing request in mailroom</p> <p>b. Assign contractor control number (CCN) to HO hearing request</p> <p>c. Scan HO hearing request and any other documentation, if applicable</p> <p>d. Forward HO hearing request to appropriate department</p> <p>e. Begin HO hearing case preparation and validate request</p> <p>f. Enter data as necessary into system/database</p>	<p>Workload 1 HO Hearings Cleared (claims) (CMS-2591, Line 7, Column 6)</p> <p>Workload 2 HO Hearings Cleared</p>

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		<p>Hearing request.</p> <p>The intermediary will continue to process Part B HO hearings for all redeterminations issued prior to May 1, 2005. For all redeterminations issued on or after May 1, 2005, a QIC will perform a reconsideration.</p> <p>Reference:</p> <ul style="list-style-type: none"> • §1869 and §1842(b)(2)(B)(ii) of the Social Security Act • Medicare Claims Processing Manual, Chap. 29, Section 50.4 	<p>g. Write and send a HO hearing acknowledgement letter</p> <p>h. Prepare the HO hearing case file</p> <p>i. Schedule the hearing</p> <p>j. Provide written notice of the hearing</p> <p>k. Pre-examine the HO hearing evidence</p> <p>l. Enter data as necessary into system/database</p> <p>m. Examine the applicable sections of the statutes, regulations, rulings, policy statements, general instructions and formal guidelines to prepare for the HO hearing</p> <p>n. Travel</p> <p>o. Conduct the HO hearing</p> <p>p. Receive medical review for the HO hearing, if necessary</p> <p>q. Make a determination about HO hearing request</p> <p>r. Write and mail a HO hearing decision letter to appellant</p> <p>s. Effectuate the decision if whole or partial reversal</p> <p>t. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible ALJ request</p>	<p>(cases) (CMS-2591, Line 6, Column 6)</p> <p>Workload 3 HO Hearings Reversed (cases) (CMS-2591, Line 11, Column 6)</p>
12160	Part B ALJ Hearing Requests and Effectuations, and DAB Referrals, Requests for Case Files, and Effectuations	<p>All costs and workloads associated with the processing of ALJ hearing requests and effectuations.</p> <p>All costs associated with processing DAB referrals, DAB requests and DAB effectuations.</p> <p>Reference:</p> <ul style="list-style-type: none"> • 42 CFR 405.855 and 42 CFR 405.856 • Medicare Claims Processing Manual, Chap. 29, Section 50.7 • CR 3530 • Joint Signature Memo 05306 <p>Misc. Code: 12160/01 – Courier Service Fee – All costs of using a courier service to forward requests for Part B ALJ hearing and case files.</p>	<p>For Part B ALJ requests and effectuations:</p> <p>a. Receive written ALJ hearing request or request for case file from ALJ office</p> <p>b. Assign CCN</p> <p>c. Scan requests, referrals, and any other documentation, if applicable</p> <p>d. Forward ALJ hearing request or case file request to appropriate department</p> <p>e. Enter data as necessary into system/database</p> <p>f. Assemble case file and make and maintain an exact copy of the file</p> <p>g. Forward case file to ALJ Hearing Office or HHS OMHA, as appropriate</p> <p>h. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals</p> <p>i. Receive and control case file and decision</p> <p>j. Compute the amount due to the appellant/party based on the decision (if whole or partial reversal)</p> <p>k. Enter data as necessary into system/database</p> <p>l. Effectuate decision, if whole or partial reversal</p> <p>m. Place documentation confirming payment has been made in the case file, if applicable</p>	<p>Workload 1 Part B ALJ Hearing Requests Forwarded (claims) (CMS-2591, Line 57, Column 5)</p> <p>Workload 2 Part B ALJ Hearing Requests Forwarded (cases) (CMS-2591, Line 56, Column 5)</p> <p>Workload 3 Part B ALJ Hearings Effectuated (cases) (CMS-2591, Line 72, Column 5)</p>

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		<ul style="list-style-type: none"> Medicare Claims Processing Manual, Chap. 29, Section 60.19.4 <p>ALJ case files forwarded on or after June 30, 2005 will be processed by HHS ALJs. The DAB referral process for these cases will no longer be the responsibility of the contractor.</p>	<p>n. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals</p> <p>o. For all decisions issued by HHS, effectuate action only in response to formal decision</p> <p>p. Obtain written assurance from provider, as needed</p> <p>q. Calculate payment, in accordance with CR 3530</p> <p>r. Notify AdQIC within 14 days of payment</p>	
			<p>For Part B DAB referrals, requests for case files and effectuations (from SSA ALJs – HHA ALJ referrals will be handled by the QIC):</p> <p>a. Prepare draft Agency Referral memo and case file, and forward with the original ALJ case file to lead RO within 30 days of the date of the ALJ decision</p> <p>b. Receive and control the appellant's DAB review request or the DAB's request for a case file</p> <p>c. Retrieve case file</p> <p>d. Copy any additional correspondence and make a copy of the original case file and maintain</p> <p>e. Send original case file to the DAB</p> <p>f. Effectuate DAB's decision</p> <p>g. Enter case status information throughout the process of this activity and update as necessary</p>	

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CAFM Code	Activity Name	Definition	Tasks	Workload
12180	Qualified Independent Contractor Support Services	<p>Report all costs workloads associated with preparation and forwarding of case files to the QIC, including additional support and coordination activities not related to case file development, as well as the effectuation of QIC decisions.</p> <ul style="list-style-type: none"> • CR 3530 	<p>a. Send misrouted/misfiled requests received by the contractor to the QIC within 14 days of receipt in the corporate mailroom.</p> <p>b. Track to ensure receipt at the proper QIC</p> <p>c. Prepare case files in accordance with CR 3530</p> <p>d. Transmit case files requested by QIC within 7 calendar days of the request.</p> <p>e. Send case files in accordance with Joint Operating Agreement (JOA) or by courier so it is received by the 8th calendar day before the request.</p> <p>f. If agreed upon in JOA, maintain e-mail account for receipt of case file requests from QIC</p> <p>g. Upon receipt of e-mail request from QIC for case files, notify QIC</p> <p>h. Effectuate only in response to formal decision from the QIC.</p> <p>i. Obtain written assurance from provider, if necessary.</p> <p>j. Effectuate timely, in accordance with 3530.</p> <p>k. Report payment amount and date of payment to appropriate QIC within 14 days of date of payment.</p>	<p>Workload 1 Preparation and Forwarding of Case Files to QIC (claims) (not currently captured on CMS 2591)</p> <p>Workload 2 Preparation and Forwarding of Case Files to QIC (cases) (not currently captured on CMS 2591)</p> <p>Workload 3 QIC Decisions Effectuated (claims) (not currently captured on CMS 2591)</p>

FY 2006 Appeals Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
12190	Clerical Error Reopenings	<p>Report all costs and workloads associated with conducting clerical error reopenings. Reopenings are appropriate for the correction of minor errors and omissions. Reopenings may be conducted by telephone or in writing</p> <ul style="list-style-type: none"> • CR 3530; • Medicare Claims Processing Manual, Chap. 29, Section 90 	<p>a. Accept all pertinent information on the errors or omissions affecting the claim over the phone or in writing</p> <p>b. Determine if errors or omissions are minor clerical errors that can be handled as a reopening.</p> <p>c. Log request into system and assign control number</p> <p>d. Enter data, as necessary, into the system or database</p> <p>e. Conduct the reopening and correct clerical errors</p> <p>f. Review claim, based on accurate information; make adjustments, if necessary</p> <p>g. Mail review decision letter to parties, if the decision is unfavorable. If favorable, send a MSN or RA</p> <p>h. Forward request to appropriate department if it can't be handled as a reopening</p>	<p>Workload 1 Clerical Error Reopenings Completed (claims) (not currently captured on CMS 2591)</p> <p>Workload 3 Clerical Error Reopening Reversals (claims) (not currently captured on CMS 2591)</p>
12901	PM CERT Support	<p>All PM costs associated with supporting the Comprehensive Error Rate Testing (CERT) contractor.</p> <p>Reference:</p> <ul style="list-style-type: none"> • Program Integrity Manual (PIM) Chapter 12, Section 3.3.1 • PIM Chapter 12, Section 3.4 • PIM Chapter 12, Section 3.5 • PIM Chapter 12, Section 3.6.1 • PIM Chapter 12, Section 3.6.2 	<p>a. Provide sample information to the CERT Contractor as described in Pub 100-8 Ch. 12 § 3.3.1A&B</p> <p>b. Ensure that the correct provider address is supplied to the CERT Contractor as described in Pub 100-8 Ch 12 § 3.3.1.C</p> <p>c. Research 'no resolution' cases as described in Pub 100-8 Ch 12 § 3.3.1.B</p> <p>d. Handle and track CERT-initiated overpayments/underpayments as described in Pub 100-8 Ch 12. § 3.4 and 3.6.1</p> <p>e. Handle and track appeals of CERT-initiated denials as described in Pub 100-8 Ch 12. § 3.5 and 3.6.2</p>	

FY 2006 Beneficiary Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
13002	Beneficiary Written Inquiries	<p>All costs associated with answering written beneficiary/Congressional questions.</p> <p>All costs associated with answering questions from beneficiaries visiting the Medicare Contractor facility.</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2, Section 20.2 	<p>a. Log/Control and stamp all written inquiries with receipt date in mailroom</p> <p>b. Answer Inquiry in writing, via telephone, or e-mail</p> <p>c. Send response</p> <p>d. Maintain Quality Control Program for written policies and procedures</p> <p>e. Transfer misrouted correspondence</p> <p>f. Maintain the Quality Written Correspondence Monitoring (QWCM) program</p> <p>g. Perform continuous quality reviews of outgoing letters</p> <p>h. Answer visitors' questions courteously and responsively (formerly walk-in inquiries)</p>	<p>Workload 1 is the cumulative written inquiries as reported on the CMS-1566, Line 37, Beneficiary Column.</p> <p>Workload 2 is the cumulative visitor inquiries (formerly walk-ins) as reported on the CMS-1566, Line 36, Beneficiary Column.</p>
13004	Customer Service Plans	<p>All costs associated providing beneficiary outreach and educational seminars, conferences and meetings for the contractor's entire geographic area and not limited to the local RO.</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2, Section 20.5 	<p>a. Establish partnerships and collaborate with local and national coalitions and beneficiary counseling and assistance groups</p> <p>b. Provide service to areas with high concentrations of non-English speaking populations and for special populations such as: blind, deaf, disabled and any other vulnerable population of Medicare beneficiaries</p> <p>c. Conduct Medicare awareness training/education with appropriate Congressional staffs to resolve beneficiary issues with Medicare</p>	

FY 2006 Beneficiary Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
13005	Beneficiary Telephone Inquiries	<p>All costs associated with answering beneficiary/Congressional questions over the telephone.</p> <p>All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response.</p> <p>All costs associated with planning/conducting training; and inputting/reviewing performance data.</p> <p>All costs associated with NGD deployment and operation.</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2, Section 20.1 	<p>a. Answer telephones</p> <p>b. Completing internal paperwork</p> <p>c. Inputting data into the system</p> <p>d. Analyzing reports and data</p> <p>e. Mailing information requested</p> <p>f. Making follow-up calls</p> <p>g. Monitoring Call</p> <p>h. Completing Scorecard</p> <p>i. Inputting Scorecard</p> <p>j. Reviewing Scorecard with CSR</p> <p>k. Planning/conducting training for CSRs</p> <p>l. Planning and deployment of NGD</p>	<p>Workload 1 is the cumulative inquiries as reported on the CMS-1566, Line 35, Beneficiary Column.</p>
13201	Second Level Screening of Complaints Alleging Fraud and Abuse	<p>Costs associated with screening second level beneficiary inquiries of potential fraud and abuse, ordering medical records for beneficiary inquiries, and sending the referral package to the PSC or Medicare fee-for-service contractor BIU. This also includes the costs associated with the referral package for provider inquiries of potential fraud and abuse.</p> <p>Workload associated only with beneficiaries.</p> <p>13201/01 – Second Level of Complaints Alleging Fraud and Abuse by Providers – Costs</p>	<p>The tasks below are associated with beneficiary inquiries only.</p> <p>a. Calls the beneficiary (PIM Chapter 4, §4.6-4.6.2)</p> <p>b. Reviews claims history (PIM Chapter 4, §4.6-4.6.2)</p> <p>c. Reviews provider correspondence files for educational/warning letters or contact reports that relate to similar complaints (PIM Chapter 4, §4.6-4.6.2)</p> <p>d. Requests itemized billing statements, when necessary (PIM Chapter 4, §4.6-4.6.2)</p> <p>e. Requests medical records, when necessary (PIM Chapter 4, §4.6-4.6.2)</p> <p>f. Resolves complaints, whenever possible (PIM Chapter 4, §4.6-4.6.2)</p> <p>g. Refers complaints that are not fraud and abuse to the appropriate staff within the contractor or PSC, if</p>	<p>Workload 1 The total number of second level screening inquiries for beneficiaries that were closed (count the same complaint only once).</p> <p>Workload 2 The total number of medical records ordered for beneficiary inquiries that were closed (report the same complaint only once).</p> <p>Workload 3 The total number of potential beneficiary fraud and abuse</p>

FY 2006 Beneficiary Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		associated with the referral package for provider inquiries of potential fraud and abuse.	<p>appropriate (PIM Chapter 4, §4.6-4.6.2)</p> <p>h. Screens all Harkin Grantee complaints for fraud and abuse and maintains the Harkin Grantee Database (PIM Chapter 4, §4.6-4.6.2, §4.12.3-4.12.4)</p> <p>i. Compiles information in the Database into an aggregate report (PIM Chapter 4, §4.12.4)</p> <p>j. Distributes the aggregate report to the Harkin Grantee state project coordinator every 6 months and send copies of the report to CMS CO (PIM Chapter 4, §4.12.4)</p> <p>k. Screens all OIG Hotline complaints for fraud and abuse (PIM Chapter 4, §4.6-4.6.2)</p> <p>l. Develops the referral package for the PSC or Medicare fee-for-service contractor BIU on fraud and abuse complaints (PIM Chapter 4, §4.6-4.6.2)</p> <p>m. Refers the referral package to the PSC or Medicare fee-for-service contractor BIU within the timeframes specified in the PIM (PIM Chapter 4, §4.6-4.6.2)</p> <p>n. Maintains statistics and reports, as required (PIM Chapter 4, §4.6-4.6.2)</p>	complaints identified and referred to the PSC or Medicare fee-for-service contractor BIU.

FY 2006 Provider Communication (PCOM – PM) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
14101	Provider/Supplier Information and Education Website and “Ask the Contractor” Teleconferences	<p>All costs associated with maintaining an Internet web site that is dedicated to furnishing providers and suppliers with timely, accessible and understandable Medicare program information. All costs associated with the planning, holding and follow-up activities for “Ask the Contractor” Teleconferences (ACT).</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Section 20.1.7 CR 3376 	<p>a. Develop a website that is consistent with CMS requirements and website functionality</p> <p>b. Periodically review the Web site standards Guidelines for compliance</p> <p>c. Planning ACT</p> <p>d. Arranging and acquiring telecommunications and other facilities needed for ACT</p> <p>e. Conducting ACT</p> <p>f. Follow-up activities resulting from ACT</p>	<p>Workload 1 is the number of page views at the URL (root) level for your provider education web site.</p> <p>Workload 2 is the number of ACTs held.</p> <p>Workload 3 is the number of ACT provider attendees.</p>
14102	Electronic Mailing Lists/List-Servs	<p>All costs associated with the development and maintenance of electronic list-servs.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Section 20.1.7 	<p>a. Provide registrants via e-mail of important and time sensitive Medicare program information</p> <p>b. Notify registrants of the availability of contractor bulletins</p> <p>c. Ensure that list-serv accommodates all providers/suppliers</p>	<p>Workload 1 is the total number of contractor provider/supplier PCOM electronic mailing lists.*</p> <p>Workload 2 is the total number of unique registrants on all the PCOM electronic mailing lists.*</p> <p>Workload 3 is the number of times contractors have used their list-serv(s) to communicate with providers/suppliers.</p> <p>* Enter monthly, not cumulative, numbers</p>

FY 2006 Provider Communication (PCOM – PM) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
14201	Training and Education Tailored to Small Providers	<p>All costs associated with the development, implementation and follow-up activities related to training tailored for small providers.</p> <p>Reference:</p> <ul style="list-style-type: none"> CR 3376 	<p>a. Activities associated with identifying small providers</p> <p>b. Activities associated with reaching or marketing programs, events or products to small providers</p> <p>c. Developing, designing or producing educational programs or products for small providers</p> <p>d. Arranging and acquiring telecommunications and other facilities needed for small provider training events or programs</p> <p>e. Conducting events or programs tailored to small providers</p>	<p>Workload 1 is the total number of in person events or programs held that were tailored to small providers.</p> <p>Workload 2 is the number of electronic (web-based, telephone) events or programs held or offered that were tailored to small providers.</p> <p>Workload 3 is the number of attendees at in person events or programs tailored to small providers.</p>
14202	Training and Education Tailored to Reduce the Claims Error Rate	<p>All costs associated with the development, implementation and follow-up activities related to training and education related to reducing the Claims Error Rate.</p> <p>Reference:</p> <ul style="list-style-type: none"> CR 3376 	<p>a. Developing, designing or producing educational programs, events or products tailored to reducing the claims error rate</p> <p>b. Activities associated with reaching or marketing programs, events or products designed to reduce the claims error rate</p> <p>c. Arranging and acquiring telecommunications and other facilities needed for events or programs tailored to reduce the claims error rate</p> <p>d. Conducting events or programs tailored to reduce the claims error rate</p>	<p>Workload 1 is the total number of in person events or programs held that were tailored to reducing the claims error rate.</p> <p>Workload 2 is the number of electronic (web-based, telephone) events or programs held or offered that were tailored to reducing the claims error rate.</p> <p>Workload 3 is the number of attendees at in person events or programs tailored to reduce the claims error rate.</p>

FY 2006 Reimbursement Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
16002	Non-MSP Debt Collection/Referral	<p>Recover overpayments</p> <p>Reference:</p> <ul style="list-style-type: none"> • 42 CFR 405.370 	<p>a. Promptly suspend payments to providers to help assure the proper recovery of program overpayments and to help reduce the risk of uncollectable accounts</p> <p>b. Verify bankruptcy information for accuracy, timeliness, and coordinate with CMS/OGC to ensure proper treatment and collection of any overpayments to the Trust Funds</p> <p>c. Record overpayments determined by functional areas timely (including Interest)</p> <p>d. Refer all eligible delinquent debt to Treasury within 180 days of the debt becoming delinquent. (Do not include MSP debt referral on this line)</p> <p>e. Promptly review all extended repayment plan requests. Coordinate with regional and central office on Extended Repayment Plans (ERs) that are over 12 months</p> <p>f. Adjust recoupment of non cost report overpayments upon appeal as required under Section 1893 (f) 1893 (2) (MMA 935).</p>	
16003	Interim Payment Control	<p>Establish, review, and revise interim payments rates</p> <p>Reference:</p> <ul style="list-style-type: none"> • 42 CFR 413.64 (h) • 42 CFR 412.116(b) • Provider Reimbursement Manual 15 Part 1 • Intermediary Manual/ Part I 	<p>a. Review and adjust provider's periodic interim payment (PIP) payments. Monitor provider compliance with PIP requirements and terminate providers from PIP, when necessary</p> <p>b. Review/revise interim rates for non-PPS providers. Review/revise Graduate Medical Education (GME), Indirect Medical Education (IME), Disproportionate Share Hospital (DSH), bad debt, organ acquisition, etc. interim rates. Ensure the accuracy of all interim payments by making lump sum adjustments when needed</p> <p>c. Review documentation requests for special payment status such as sole community and Medicare dependent hospital.</p>	Workload 1 is the number of provider interim rate reviews, including PIP reviews.
16004	Reimbursement Report and File Maintenance	<p>Maintain data reports and files for provider reimbursement</p> <p>Reference:</p> <ul style="list-style-type: none"> • 42 CFR Part 413 • Program Memorandum 2197 under PM A-03-004 	<p>a. Maintain accurate PPS Pricer Prov (provider specific) file</p> <p>b. Ensure an accurate System for Tracking Audit and Reimbursement (STAR) database is maintained, including ensuring that all information is properly entered and reported</p> <p>c. Maintain the Provider Statistical and Reimbursement (PS&R) system including testing all system updates and ensuring data is reliable for cost report settlements</p> <p>d. Obtain cost reports from providers including issuance of cost report</p>	

FY 2006 Reimbursement Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		<ul style="list-style-type: none"> Provider Reimbursement Manual 15 Part 1 	submission reminder letters, PS&R reports, and demand letters e. Generate and submit HCRIS files f. Update provider specific files for all payment factors (e.g., DSH, IME, CCR, etc.) g. Calculate and notify providers of applicable limits and caps (e.g. TEFRA, ESRD, Hospice, etc.) h. Answer information requests from CMS, OIG, DOJ, FBI, and GAO including FOIA requests related to reimbursement activities	
16005	Provider-Based Regulations	Carry out all functions related to making provider-based determinations. Reference: <ul style="list-style-type: none"> 42 CFR 413.65 CR 2411 	a. Process all provider applications or attestations and review all applications or attestations for completeness and accuracy b. Make any necessary on-site visits c. Carry out random sample reviews of providers that have not submitted any attestations or applications d. Take any necessary review or audit steps needed to allow CMS to make final provider-based determinations	<p>Workload 1 is the number of recommendations for approval made to the regional office (RO).</p> <p>Workload 2 is the number of recommendations for disapproval made to the RO.</p> <p>Workload 3 is the number of attestations received, but for which recommendations have not yet been made to the RO.</p>

FY 2006 Provider/Supplier Enrollment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks*	Workload
31001	Provider Enrollment	<p>Provider/supplier enrollment is a critical function to ensure only qualified healthcare organizations and entities are enrolled in the Medicare program. Healthcare organizations and entities must enroll with Fiscal Intermediaries (FIs), with whom they will do business, before receiving reimbursement for services furnished to Medicare beneficiaries. Each applicant will use the appropriate enrollment form and undergo the entire enrollment process, including verification of all of their information.</p> <p>Reference:</p> <ul style="list-style-type: none"> PIM Chapter 10* 	<p>a. Distribute all enrollment applications or refer applicants to the CMS web site (§2.2 and 23)</p> <p>b. Process initial applications (CMS 855A) from receipt to final recommendation, including verification of information and meeting CMS timeliness standards (§ 1, 2, 10 - 12, 14 - 21)</p> <p>c. Process and verify Changes of Ownership (CHOWs), acquisitions/mergers and consolidations within CMS timeliness standards (§10)</p> <p>d. Process, verify and acknowledge changes of information via the CMS 855A within CMS timeliness standards. (§3,13)</p> <p>e. Process voluntary termination of billing numbers via the CMS-855A (§10.1)</p> <p>f. Verify and document provider enrollment information using the Qualifier.Net, etc (§2.2)</p> <p>g. Image applications (i.e., for authorized and delegated official signatures) or maintain a hardcopy file to compare the signatures of the authorized official and delegated official for changes to “pay-to” address (§2.2)</p> <p>h. Enter all application information into the Provider Enrollment, Chain, and Ownership System (PECOS)</p> <p>i. Monitor Community Mental Health Centers (CMHCs) and deactivate non-billing CMHCs (§11)</p> <p>j. Ensure staff is trained on enrollment requirements, procedures and techniques (§2)</p> <p>k. Respond to all phone calls, e-mails and miscellaneous letters concerning enrollment in the Medicare program. Provider enrollment-initiated educational projects should be charged to provider enrollment. Activities done in conjunction with the Provider Communications (PCOMM) group should be charged to the PCOMM line (§22)</p> <p>l. Coordinate with other internal components (e.g., appeals, EFT processor, provider education/professional relations, ROs etc.). For EFTs, only charge provider enrollment for mailing the EFT</p>	<p>Workload 1 comprises initial applications (CMS 885A) and buyer changes of ownership (CHOWs) received in a month. CHOWs include acquisitions/mergers received in a month.</p> <p>Workload 2 is the changes of information (including seller CHOWs) received in a month. CHOWs include acquisitions/mergers and consolidations.</p>

FY 2006 Provider/Supplier Enrollment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks*	Workload
			<p>form in the new provider packet and the verification of the bank account per CMS Pub 100-04, §30.2. (§2).</p> <p>m. Coordinate with other external components (e.g., OIG, Medicaid, FBI, Payment Safeguard Contractors (PSCs), carriers and other FIs, State survey and certification agencies, etc.). When working with PSCs, the FI will charge their assistance to a PSC under one of the three designated workloads (see activity code 23201). Work not associated with one of these workloads is charged to provider enrollment (§2, 27)</p> <p>n. Document all internal or external contacts and verifications (§25)</p> <p>o. Provide a link to the provider enrollment web site from your contractor web site (§23)</p>	

FY 2006 Provider Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
33001	Answering Provider Telephone Inquiries	<p>All costs associated with answering provider questions over the telephone.</p> <p>Reference: IOM Pub 100-9 Chapter 3 §20.1.1-20.1.5 IOM Pub 100-9 Chapter 3 §20.1.8-20.1.12 CR 3376</p> <p>Misc. Code: 33001/02 – IVR costs – All costs associated with the automated handling of a provider inquiry via an IVR.</p>	<ul style="list-style-type: none"> a. Answering the phones timely b. Completing internal paperwork c. Inputting data into the system d. Analyzing reports and data e. Sending requested information f. Making follow-up calls g. Implementing a provider satisfaction survey h. Developing a contingency plan i. Developing an IVR quality assurance plan j. All costs associated with purchasing and maintaining telephone systems and equipment k. Maintaining an inquiry tracking system l. All costs associated with purchasing and maintaining an IVR system 	Workload 1 is the cumulative inquiries as reported on the HCFA-1566, Line 35, Provider Column
33014	Provider Inquiry Quality Monitoring	<p>All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response as well as the costs of monitoring the quality of written correspondence.</p> <p>Reference: IOM Pub 100-9 Chapter 3 §20.1.7 CR3376</p>	<ul style="list-style-type: none"> a. Monitoring Calls b. Completing and inputting QCM Scorecard c. Reviewing QCM Scorecard with CSR d. Reviewing written correspondence, including that generated by Provider Relations Research Specialists. e. Completing and inputting QWCM Scorecard 	
33020	Staff Development and Training	<p>All costs associated with the training and development of provider inquiries staff.</p> <p>Reference: IOM Pub 100-9 Chapter 3 §20.1.6 CR3376</p>	<ul style="list-style-type: none"> a. Planning/conducting training for CSRs b. Attending CMS sponsored meetings, conferences, and train-the-trainer sessions related to provider customer service c. Training activities performed by and for Provider Relations Research Specialists, including PRRS development of CSR job aids. d. Training developed/conducted by other functional areas within contractor (e.g., MSP, appeals, enrollment) <u>at request of</u> contact center. 	

FY 2006 Provider Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
33002	Provider Written Inquiries	<p>All costs associated with answering provider questions through written correspondence.</p> <p>Reference: IOM Pub 100-9 Chapter 3 §20.2 CR3376</p>	<p>a. Logging/Controlling and date stamping all written inquiries, including faxes and e-mails</p> <p>b. Responding to a written inquiry in writing, via telephone, or via e-mail</p> <p>c. Mailing the response (if applicable)</p> <p>d. Maintaining a Quality Control Program for written policies and procedures</p> <p>e. Transferring misrouted correspondence</p> <p>f. Answer visitors' general inquiries courteously and responsively (provider walk-ins)</p>	<p>Workload 1 is the number of provider written inquiries received by the contractor as reported on the CMS-1566, Line 37, Provider Column.</p> <p>Workload 2 is the number of provider written inquiries handled by the Provider Relations Research Specialists.</p> <p>Workload 3 is the cumulative provider walk-in inquiries as reported on the CMS-1566 Line 36, Provider Column.</p>

FY 2006 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21001	Automated Review	<p>When medical review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. See IOM Pub. 100-8 Ch. 3 section 5.1 for further discussion of automated review.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM Pub. 100-8 Chapter 3, Section 3.4.5 (A) • IOM Pub. 100-8 Chapter 3, Section 3.5.1 • IOM Pub. 100-8 Chapter 11, Section 11.1.3.1 	<p>a. Develop edits</p> <p>b. Implement edits</p>	<p>Workload 1 report the number of claims denied in whole or in part.</p> <p>Workload 2 report the number of claims subjected to automated medical review, to the extent that contractors can report this.</p>
21002	Routine Reviews	<p>Routine review requires the intervention of specially trained non-clinical MR staff and is restricted to determination that can be made by review of the claim, attachments not requiring clinical judgment, and review of claims history.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM Pub. 100-8 Chapter 3, Section 3.4.5 (B) • IOM Pub. 100-8 Chapter 11, Section 11.1.3.2 	<p>a. Develop edits</p> <p>b. Implement edits</p> <p>c. Review claim</p> <p>d. Make determination</p> <p>e. Generate denial letter if appropriate; <u>this does not include collecting the overpayment</u></p>	<p>Workload 1 report the number of claims subject to review.</p> <p>Workload 2 report number claims denied in whole or in part.</p> <p>Workload 3 report the number of providers subjected to routine review.</p>

FY 2006 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21007	Data Analysis	<p>Data Analysis is the integrated and on-going comparison of CERT findings, claim information, claims data deviations from standard practice, and other related data to identify potential provider service billing practices that may pose a threat to the Medicare Trust fund. This analysis can be a comparison of individual claim characteristics or in the aggregate of claims submissions. Analysis of data will lead to the generation of a list of program vulnerabilities that the contractor will use to focus their education and review resources.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM Pub. 100-8 Chapter 2, Section 2.2 • IOM Pub. 100-8 Chapter 11, Section 11.1.3.3 	<ul style="list-style-type: none"> a. Collect data b. Analyze and compare data c. Identify potential program vulnerabilities d. Institute ongoing monitoring and modification of data analysis program components e. Develop and maintain trend reports over at least an 18-month period 	There are no specific workload parameters for Data Analysis.

FY 2006 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21010	Third Party Liability (TPL) or Demand Bills	<p>Demand bills are bills submitted by the SNF or a HHA at the beneficiary's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and wishes the bill to be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. The SNF and HHA must have a written request from the beneficiary to submit the bill, unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative, or other authorized representative may make the request.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 6, Section 6.1.1 IOM Pub. 100-8 Chapter 11, Section 11.1.5 	<p>a. Review claim</p> <p>b. Request medical record and documentation</p> <p>c. Make determination for payment and determination of liability.</p> <p>d. <u>Send final decision letter to provider and beneficiary identifying payment decision and determination of provider/beneficiary liability.</u></p>	<p>Workload 1 report the number of claims (TPL and demand bills) reviewed.</p> <p>Workload 2 report the number of claims denied, in whole or in part.</p> <p>Workload 3 report the number of demand bills. (IOM Pub. 100-8 Ch. 11).</p>
21206	Policy Reconsideration/ Revision	<p>Contractors shall revise, reconsider, and/or retire Local Coverage Determinations (LCD). Costs accrued for transitioning Local Medical Review Policy (LMRP) to the LCD format should be captured here.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 11, Section 11.1.3.5 IOM Pub. 100-8 Chapter 13, Section 13.4 	<p>a. Determine need (IOM Pub. 100-8, Ch. 13, §13. 4)</p> <p>b. Develop draft LCD change</p> <p>c. Solicit comments</p> <p>d. Compile and respond to comments</p> <p>e. Develop final policy</p> <p>f. Distribute policy</p> <p>g. Post LCD on to the database</p>	<p>Workload 1 report the total number of policies/coverage determinations revised.</p> <p>Workload 2 reports the total number of policies/coverage determinations that required notice and comment.</p> <p>Workload 3 report the total number of policies/coverage determinations revised due to outside request (e.g., beneficiary or provider request).</p>

FY 2006 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21207	MR Program Management	<p>MR Program Management encompasses managerial responsibilities inherent in managing the Medical Review (MR) and Local Provider Education & Training (LPET) Programs, including development, modification and periodic reports of MR/LPET Strategies and Quarterly Analysis (QSA); quality assurance activities; planning, monitoring and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS instructions. Any MR activity required for support of a PSC that performs MR activities should also be included in this code (this does not include MR to support the CERT contractor).</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 11, Section 11.13.6 	<p>a. Review data from data analysis</p> <p>b. Develop and prioritize a problem list from data analysis</p> <p>c. Determine the educational and review activities that will be used to address the problems on the problem list</p> <p>d. Develop and periodically modify Medical Review/LPET Strategy</p> <p>e. Track and modify problem list activities by using the QSA</p> <p>f. Develop and modify quality assurance activities, including special studies, Inter-Reviewer Reliability testing, Committee meetings, and periodic reports</p> <p>g. Evaluate edit effectiveness</p> <p>h. Plan, monitor, and oversee budget, including interactions with contractor budget staff and CMS budget and MR program staff</p> <p>i. Manage workload, including monitoring of monthly workload reports, re-allocation of staff resources, and shift in workload focus when indicated</p> <p>j. Implement Medical Review instruction from Regional and/or Central Office</p> <p>k. Educate staff on Medical Review issues, new instruction, and quality assurance findings</p> <p>l. MR PSC support activities</p>	
21208	New Policy Development Activities	<p>Contractors are to create Local Coverage Determinations (LCD) IOM 100-8 Chapter 13, Section 13.4.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 13, Section 13.4 IOM Pub. 100-8 Chapter 11, Section 11.1.3.7 	<p>a. Determine need (See IOM Pub. 100-8, Ch. 13, §13.4 (A) for circumstances requiring a need for LCD development)</p> <p>b. Develop draft LCD</p> <p>c. Solicit comments</p> <p>d. Compile and respond to comments</p> <p>e. Develop final LCD</p> <p>f. Distribute LCD</p> <p>g. Post LCD on to the database</p>	<p>Workload 1 report the number of new LCDs that were presented for notice and comment.</p> <p>Workload 2 report the number of LCDs that became effective.</p>

FY 2006 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
				Workload 3 report the number of IDE requests developed.
21220	Complex Probe Review	<p>Reports all costs associated with prepay and postpay Complex Probe Review. Prepay and postpay probe reviews are done to verify that the program vulnerability identified through data analysis actually exists and will require additional education and possible review.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8, Chapter 3, Section 3.2 (A) IOM Pub. 100-8, Chapter 11, Section 11.1.3.8 	<p>a. Select sample b. Request medical records/additional information c. Review claim d. Make determination e. Generate denial letters, if appropriate; <u>this does not include collecting the overpayment</u></p>	<p>Workload 1 report the number of claims reviewed.</p> <p>Workload 2 report the number of claims denied in whole or in part.</p> <p>Workload 3 report the number of providers subjected to complex probe review.</p>
21221	Prepay Complex Review	<p>Reports all costs associated with Prepay Complex Review. Prepay medical review of claims requires that a benefit category review, statutory exclusion review, and/or reasonable and necessary review be made BEFORE claim payment. Complex medical review involves using clinical judgment by a licensed medical professional to evaluate medical records. Include only claims reviewed based on data analysis and identified in the MR/LPET strategy in this activity line.</p> <p>Reference:</p> <ul style="list-style-type: none"> 100-8 Chapter 3, Section 3.4 100-8 Chapter 3, Section 3.4.5 100-8 Chapter 11, Section 11.1.3.9 	<p>a. Develop edits b. Implement edits c. Perform quality assurance of edits d. Request medical records and additional documents e. Review claim and documentation f. Make determination g. Generate denial letters, if appropriate; <u>this does not include collecting the overpayment</u></p>	<p>Workload 1 report the number of claims reviewed.</p> <p>Workload 2 report the number of claims denied, in whole or in part.</p> <p>Workload 3 report the number of providers subjected to complex review.</p>

FY 2006 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21222	Postpay Complex Review	<p>Contractors shall report all costs associated with Post pay Complex Review. Post pay medical review of claims requires that a benefit category review, statutory exclusion review, and/or reasonable and necessary review be made AFTER claim payment. This types of review allows the contractor to make a determination to deny a claim (in full or in part) and assess an overpayment. Complex medical review involves using clinical judgment by a licensed medical professional to evaluate medical records. Include only claims reviewed based on data analysis and identified in the MR/LPET strategy in this activity line.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM Pub. 100-8 Chapter 3, Section 3.4 • IOM Pub. 100-8 Chapter 3, Section 3.4.5 • IOM Pub. 100-8 Chapter 11, Section 11.1.7.2 • IOM Pub. 100-8 Chapter 11, Section 11.1.3.10 	<ul style="list-style-type: none"> a. Select claims b. Claim review c. Request medical records and additional documents d. Claim and Documentation review e. Make determination f. Generate overpayment demand letters, if appropriate; <u>this does not include collecting the overpayment</u> 	<p>Workload 1 report the total number of claims reviewed on a postpayment basis.</p> <p>Workload 2 report the total number of claims denied in whole or in part.</p> <p>Workload 3 report the number of providers subjected to postpayment review.</p>
21210	Medical Review Re-openings	<p>When a claim is denied by the Medical Review Unit using remark code N102 or 56900 and the documentation requested is received after the 45-day deadline, or is received with the appeal request, the Appeals Unit will forward the file back to the MR Unit for re-opening.</p>	<ul style="list-style-type: none"> a. Claim and Documentation review b. Make determination c. Generate overpayment demand letters, if appropriate, <u>this does not include collecting the over payment</u> 	<p>Workload 1 report the number of reopening requests received</p> <p>Workload 2 report the number of reopening requests resulting in payment</p> <p>Workload 3 report the number of providers requesting a reopening.</p>

FY 2006 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21901	MIP Comprehensive Error Rate (CERT) Support	<p>Report the costs associated with time spent on activities to support the CERT contractor that are performed by the Medicare Integrity Program functional areas.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 12 	<p>a. Providing review information to the CERT Contractor as described in IOM Pub. 100-8 Ch. 12, § 3.3.2</p> <p>b. Providing feedback information to the CERT Contractor as described in IOM Pub. 100-8 Ch. 12, § 3.3.3, including but not limited to:</p> <ul style="list-style-type: none"> CMD discussions about CERT findings Participation in biweekly CERT conference calls Responding to inquiries from the CERT contractor Preparing dispute cases <p>c. Preparing the Error Rate Reduction Plan (ERRP) as described in IOM Pub. 100-8 Ch. 12, § 3.9</p> <p>d. Educating the provider community about CERT as described in IOM Pub. 100-8 Ch.12, § 3.8</p>	

FY 2006 Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
22001	MSP Bills/Claims Prepayment	<p>All costs of activities required to continue processing of a MSP claim after it enters the claims processing system, subsequent to initial claim entry, and activities necessary to aid in the processing of MSP Prepay-related Congressional hearings and appeals</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual, Pub 105-5, Chapters: 3, 5, 6 & 7 	<p>a. Resolve MSP claim edits occurring in the claim adjudication process within the standard systems and in response to CWF verification and validation</p> <p>b. Compare EOB/RA data attached to the MSP claim to HIMR/CWF data to identify the presence/absence of a CWF MSP Aux File record and to continue claim processing</p> <p>c. Contact the provider (for clarification- not development) if necessary, to avoid suspending the claim</p> <p>d. Add termination dates to MSP auxiliary records previously established on CWF with a “Y” validity indicator when no discrepancy exists in the validity of the CWF information and an active claim (simple terminations)</p> <p>e. Prepare an ECRS CWF Assistance Request to terminate a record only when a system problem exists or it fits existing CWF error codes/subject to the 6-month rule</p> <p>f. Work MSP suspended claims that have not processed through to final payment decision including:</p> <ul style="list-style-type: none"> -Override a claim using conditional payment codes to process the claim as primary; -Prepare an “I” record to accommodate an override -Determine to pay as primary or secondary or deny -Follow up on COBC development/actions; and -Address CWF Automatic Notices <p>g. Complete MSP ECRS Inquiries and CWF Assistance Requests necessary to process the receipt of a claim through to payment or denial – Use C in the ECRS AC field.</p> <p>h. Follow up on prepay CWF Assistance Requests within designated timeframes</p> <p>i. Create “I” records when sufficient claim information exists to add a new CWF MSP Aux File record</p> <p>j. Process Congressional inquiries related to MSP Prepay functions and follow up with COBC within designated timeframes</p>	<p>Workload 1 is the number of MSP claim edits resolved in the claim adjudication and CWF verification and validation processes and the “I” records prepared to complete the processing of a claim.</p> <p>Workload 2 is the number of ECRS MSP Inquiries and CWF Assistance Requests transmitted to the COBC.</p> <p>Workload 3 is the number of MSP prepays Congressional and hearing requests processed, including follow up with the COBC.</p>

FY 2006 Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
22005	MSP Hospital Audits/On-site Reviews	<p>All costs of activities associated with the onsite review of hospitals, completion of reports and follow-up.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual Pub 105-5, MSP Manual, Chapters: 3, 5 & 7 	<p>a. Conduct on-site hospital reviews</p> <p>b. Prepare review reports to providers</p> <p>c. Conduct follow-up on corrective action plans with providers</p>	<p>Workload 1 is the number of completed on-site reviews when a provider report has been submitted.</p>
42002	Liability, No-Fault, Workers' Compensation, Federal Tort Claim Act (FTCA)	<p>All costs performed by the lead recovery contractor of activities associated with the identification and establishment of a MSP Recovery claim specific to the named activity.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual Pub 105-5, Medicare Secondary Payer Manual, Chapters: 2, 4, 5, 6, & 7 	<p>a. Research Medicare paid claims to identify claims related to a pending settlement, judgment, or award</p> <p>b. Identify Medicare's conditional payment amount</p> <p>c. Issue subsequent conditional payment amount notices (when appropriate)</p> <p>d. Respond to all case related inquiries (includes congressional inquiries) prior to the demand.</p> <p>e. Enter appropriate termination dates to CWF</p> <p>f. Calculate the Medicare recovery amount</p> <p>g. Issue recovery demand to appropriate individual or entity</p> <p>h. Coordinate with RO all pre-demand compromise requests</p> <p>i. Coordinate with CMS to effectuate FTCA recoveries</p> <p>j. Follow CMS directives for access to OSCAR, UPIN, & NSC data. Use R in the ECRS AC field</p>	<p>Workload 1 is the number of recovery demand letters issued.</p> <p>Workload 2 is the number of <u>incoming correspondence</u> and the newly identified leads upon status code changed to UIR in ReMAS.</p> <p>Workload 3 is the number of resultant ECRS transactions.</p>

FY 2006 Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
42003	Group Health Plan	<p>All costs of activities associated with recovery of all Medicare mistaken payments specific to the named activity.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual Pub 105-5, Medicare Secondary Payer Manual, Chapters: 3 & 6 	<p>a. Install/run Data Match tapes</p> <p>b. Perform all Data Match and Non-Data Match history searches</p> <p>c. Develop & issue recovery demand letters (Data Match, Non-Data Match and DPP demands, as well as, demands resulting from 42 CFR 411.25 notices) taking into account existing search parameters and tolerances, if any</p> <p>d. Check CWF prior to mailing of recovery demands, if contractors' systems will not recognize an existing termination date on an MSP record, to ensure valid MSP periods</p> <p>e. Respond to any pre-demand Data Match & Non-Data Match incoming CORR related to a case</p> <p>f. Send copies of initial demand letters to the insurer/TP of that employer (debtor)</p> <p>g. Perform all MPARTS status code updates related to actions up to and through the issuance of a recovery demand</p> <p>h. Perform appropriate case related ECRS transactions. Use G in the ECRS AC field</p>	<p>Workload 1 is the number of GHP recovery demand letters issued to the debtor (do not count the copy).</p> <p>Workload 2 is the number of MSP post payment case-related ECRS transactions performed.</p>
42004	MSP General Inquires	<p>All costs of activities associated to MSP CORR that is <u>not case or active claim specific</u>.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual Pub 105-5, Medicare Secondary Payer Manual, Chapters 3, 5, & 6 	<p>a. Perform appropriate general (non-case related and non-active claim related) ECRS transactions, including those that may be necessary for voluntary refunds/unsolicited refunds. Use I in the ECRS AC field. Take action on non-active claim and non-case related letters (including voluntary refunds/unsolicited refunds), faxes, e-mails, or telephone inquiries</p> <p>b. Respond to one time inquiries for outreach materials which may include the reproduction of these materials (those not counted in 42006)</p> <p>c. Enter non-case related and non-active claim related CWF termination dates</p> <p>d. Respond to OBRA 93 requests not related to an existing debt</p>	<p>Workload 1 is the number of general MSP inquiries resolved. This includes OBRA 93 requests.</p> <p>Workload 2 is the number of non-case related & non-active claim related ECRS transactions performed specific to voluntary/unsolicited refunds.</p> <p>Workload 3 is the number of one-time inquiries requesting outreach materials.</p>
42021	Debt Collection/Referral	<p>All costs of activities associated with the collection of all MSP debts and the referral of eligible delinquent MSP debt under the Debt Collection</p>	<p>a. Ensure proper recovery of MSP debts</p> <p>b. Respond and resolve all CORR or other inquiries regarding a debt within timelines parameters</p> <p>c. Adjudicate and post checks received timely</p>	<p>Workload 1 is the number of responses to initial demand letters received from the debtor /agent</p>

FY 2006 Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		<p>Act of 1996.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual Pub 105-5, Medicare Secondary Payer Manual, Chapters: 3, 5, 6 & 7 	<p>d. Review and respond timely to “Extended Repayment Plan” (ERP) requests and monitor ongoing ERPs</p> <p>e. Resolve all post demand 1870 waiver requests</p> <p>f. Validate debts using CWF and address all pending CORR specific to the debt prior to issuing the “Intent to Refer” (ITR) letter</p> <p>g. Issue ITRs to the appropriate individual or entity (includes the copy of initial demand package)</p> <p>h. Resolve all Treasury Action form (TAFs) requests</p> <p>i. Perform appropriate recall actions and update all internal systems to reflect the progression of the debt resolution (e.g., MPARTS, DCS)</p> <p>j. Refer delinquent debts, as appropriate to Treasury</p> <p>k. Update all systems to reflect actions detailed on the Collections, Reconciliation/Acknowledgement form (CRAF)</p> <p>l. Perform appropriate debt related ECRS transactions (ECRS CWF Assistance Requests & MSP inquiries). Use D in the ECRS AC field.</p> <p>m. Take appropriate referral actions for all compromise or waiver of interest requests</p> <p>n. Develop/complete write-off – closed recommendation reports</p> <p>o. Ensure all MSP report detail are available and complete and can support reported figures (i.e., MSP savings)</p>	<p>(i.e., checks and/or CORR).</p> <p>Workload 2 is the number of ITRs letters to Treasury issued plus the number of responses received from ITRs (i.e., checks or CORR).</p> <p>Workload 3 is the number of actual referrals to Treasury plus the number of TAFs received.</p>

FY 2006 Benefit Integrity Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definitions	Tasks	Workload
23201	PSC Support Services	<p>The services that the AC will provide to support the BI activities being performed by the PSC (PIM)</p> <p>Misc. Codes: 23201/01 ACs record the total costs associated with miscellaneous PSC support services (e.g., training and meetings). 23201/02 ACs record the total costs associated with requests (not law enforcement requests) that they fulfill to support the PSC in investigations. 23201/03 ACs record the total costs associated with PSC requests for support from the AC with law enforcement requests.</p>	<p>a. Perform training for the PSC (PIM chapter 4 section 4.1) b. Conduct meetings in support of the PSC (PIM chapter 4, section 4.1) c. Prepare/supply additional documentation at the request of the PSC (PIM chapter 4, section 4.1) d. Install edits at the request of the PSC (PIM chapter 4, section 4.1)</p>	<p>Workload 1 is the number of Miscellaneous PSC support services.</p> <p>Workload 2 is the number of requests (not law enforcement) to support the PSC in investigations.</p> <p>Workload 3 is the number of PSC requests for support from the AC with law enforcement requests.</p>

FY 2006 Local Provider Education & Training (LPET)

Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
24116	One-on-One Provider Education	<p>Contractors shall initiate provider one-on-one education in response to medical review related coverage, coding and billing problems identified, verified and prioritized through the analysis of information from various sources, including CERT findings and the medical review of claims. These educational contacts require clinical expertise and include face-to-face meetings, telephone conferences, or letters and electronic communications to a provider that address the provider's specific coding, coverage and billing issue. Included in this activity code are the costs and workload included in responding to provider questions concerning their specific medical review activities, or new or revised local policies.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM 100-8 Chapter 1, Section 1.4.1.1 • IOM 100-8 Chapter 11, Section 11.2.2.1 	<p>a. Analyze problem-specific data</p> <p>b. Determine appropriate educational method based on scope of problem</p> <p>c. Develop/produce educational information</p> <p>d. Deliver education</p>	<p>Workload 1 report the number of educational contacts.</p> <p>Workload 2 report the number of providers educated.</p>
24117	Education Delivered to a Group of Providers	<p>To remedy wide spread service-specific aberrancies, intermediaries may elect to educate a group of providers, rather than provide one-on-one contacts. Education delivered to a group of providers includes seminars, workshops, teleconferences, classes, and other face-to-face meetings to educate and train providers regarding Local Coverage Determinations (LCD), coverage, coding and billing considerations, and service or specialty specific issues. Clinical staff must be used as a resource.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM 100-8 Chapter 1, Section 1.4.1.2 • IOM 100-8 Chapter 11, Section 11.2.2.2 	<p>a. Analyze problem-specific data</p> <p>b. Determine appropriate educational method based on scope of problem</p> <p>c. Gather resources, including clinical staff expertise, and develop/produce educational information</p> <p>d. Select focus groups or site visits/meetings. If feasible, collaborate with partner groups in holding events</p> <p>e. Hold educational meeting with the presence of clinical staff</p>	<p>Workload 1 report the number of educational contacts.</p> <p>Workload 2 report the number of providers educated.</p>
24118	Education Delivered via	Education delivered solely via paper media or electronically, without any live interactions is included	<p>a. Analyze problem-specific data</p> <p>b. Develop and disseminate web-based searchable</p>	Workload 1 report the number of educational

FY 2006 Local Provider Education & Training (LPET)

Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
	Electronic or Paper Media	<p>here. Contractors shall maintain a website and adhere to instruction regarding them (IOM 100-8 Chapter 1, Sec. 5.A.9). Examples of this type of education include, but are not limited to, the development and dissemination of frequently asked questions (FAQs), scripted response documents, bulletin articles, LCD postings, comparative billing reports (CBRs) issued for other than one-on-one provider education.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM 100-8 Chapter 1, Section 1.4.1.3 IOM 100-8 Chapter 11, Section 11.2.2..3 	<p>FAQs</p> <p>c. Develop and disseminate bulletin articles</p> <p>d. Develop and disseminate CBRs</p> <p>e. Develop and disseminate other types of electronic or paper media education</p>	<p>documents developed for use in non-interactive educational interventions.</p> <p>Workload 2 report the number of CBRs developed (do not include CBRs developed for activities in 24116 and 24117).</p> <p>Workload 3 report the number of articles/advisories/bulletins developed.</p>

FY 2006 Provider Communication (PCOM – MIP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
25103	Create/Produce and Maintain Educational Bulletins	<p>All costs associated with the development, production and dissemination of provider bulletins/newsletters.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-9, Chapter 4, Section 20.1.5 	<p>a. Gather resources and information to use in developing bulletin</p> <p>b. Develop bulletin</p> <p>c. Publish bulletin</p> <p>d. Disseminate bulletin</p>	<p>Workload 1 is the total number of bulletin editions published.</p> <p>Workload 2 is the total number of bulletins mailed.</p>
25105	Partner with External Entities	<p>All costs associated with the establishment and maintenance of collaborative provider education efforts with external entities.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Section 20.1.12 	<p>a. Contact/communicate with external groups or organizations</p> <p>b. Work with external groups to foster and develop collaborative PET activities</p> <p>c. Obtain feedback on effectiveness and reach of partnering efforts</p>	<p>Workload 1 is the actual number of partnering activities or efforts with entities other than the PCOM Advisory Committee.</p>
25201	Administration and Management of PCOM Program	<p>All costs associated with administering and managing the provider communications program. Includes: research analysis and identification of provider education needs; planning of educational strategies, approaches, or efforts; training of staff in support education initiatives; and reporting of provider education activities and efforts. All costs associated with developing plans to outline the strategies, projected activities, efforts, and approaches that will be used in the forthcoming year to support physician/supplier education and training.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Sections 20.1.1,2,3,10,11 & 20.2.1 	<p>a. Develop and submit PSP Report</p> <p>b. Develop and submit Quarterly Activity Reports</p> <p>c. Develop and maintain a provider inquiry analysis program</p> <p>d. Tally and analyze claim submission errors</p> <p>e. Solicit and analyze provider feedback</p> <p>f. Development and research responses to referrals of provider inquiries that are outside a PRRS mechanism</p> <p>g. Hold periodic meetings with other contractor staff to ensure that issues raised by providers are being addressed through education</p> <p>h. Send at least one training representative to between 2-4 CMS-sponsored training events</p>	<p>Workload 1 is the number of provider inquiries referred to the provider communications area requiring technical experience, knowledge or research to answer that are not handled by PRRS (AC 33002).</p>

FY 2006 Provider Communication (PCOM – MIP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
25202	Develop Provider Education Material and Information	<p>All costs associated with the planning, design, research, writing and development of materials and information used to support provider education and training efforts. This includes work for new as well as substantially revised materials or information.</p> <p>Misc. Code: 25202/01 - Special Media - for costs associated with preparation of special media.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Sections 20.1.14 	<p>a. Plan materials b. Research needed information c. Design, layout materials d. Write, illustrate or revise material e. Duplicate materials f. Prepare special media educational presentations (discretionary)</p>	<p>Workload 1 is the number of special media efforts developed.*</p> <p>* Enter monthly, not cumulative, numbers</p>
25203	Disseminate Provider Information	<p>All costs associated with holding workshops seminars, classes and other provider education events or face-to-face meetings. (Does NOT include activities related to creation of bulletins or newsletters.)</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Sections 20.1.6, .8, .9,.13. 	<p>a. Hold workshops, seminars, classes and other face to face meetings b. Disseminate Medicare provider information or materials at other provider education events or opportunities</p>	<p>Workload 1 is the number of educational seminars, workshops, classes and face-to-face meetings held.</p> <p>Workload 2 is the number of attendees at your educational seminar workshops, classes and face-to-face training.</p>
25204	Management and Operation of PCOM Advisory Group	<p>All costs associated with the management and operation of the PCOM Advisory Group (formerly the PET Advisory Group).</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Sections 20.1.4 	<p>a. Arrange PCOM Advisory Group meetings b. Solicit and maintain membership c. Obtain materials, supplies and equipment for meetings d. Produce and distribute PCOM Advisory Group information (agenda, minutes, etc.)</p>	

FY 2006 Audit Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
26001	Provider Desk Reviews	<p>Includes activities related to the cost report acceptance, tentative settlement, desk review and audit scoping.</p> <p>Reference:</p> <ul style="list-style-type: none"> CMS Medicare Manual System Pub 100-06 Financial Management Chapter 8 Sections 10-20 	<p>a. Initial review to make sure the cost report is complete and acceptable</p> <p>b. Complete the Automated Desk Review (ADR)</p> <p>c. Cursory review and initial tentative settlement determination</p> <p>d. Professional desk review including the resolution of issues via phone or letter</p> <p>e. The determination of whether a field audit is to be performed and if so the scope</p> <p>f. Review of updated PS&R if cost report is not subjected to a field audit.</p> <p>g. Final review and approval of these procedures by a supervisor</p>	<p>Workload 1 is Line 2a of the CASR IER, the total number of units (cost reports) when the desk reviews are completed. Line 2a is the total of lines 3a and 4a.</p> <p>Workload 2 is Line 3a, the number of limited desk reviews.</p> <p>Workload 3 is Line 4a, the number of full desk reviews.</p>
26002	Provider Audits	<p>Include all activities after the desk review but prior to the settlement.</p> <p>Reference:</p> <ul style="list-style-type: none"> CMS Medicare Manual System Pub 100-06 Financial Management Chapter 8 Sections 30-80 	<p>a. Preliminary audit work including reviewing prior years workpapers</p> <p>b. Review of updated PS&R if cost report is subjected to a field audit</p> <p>c. All on-site audit work and proposed audit adjustments</p> <p>d. The entrance and exit conference</p> <p>f. The preparation of the final audit adjustment report</p> <p>g. Final review of the results by the supervisor</p>	<p>Workload 1 is Line 6b of the CASR IER.</p>
26003	Provider Settlements	<p>Includes all work performed after the desk review/field audit through the NPR issuance. Do not include any appeal or hearing work.</p> <p>Reference:</p> <ul style="list-style-type: none"> CMS Medicare Manual System Pub 100-06 Financial Management Chapter 8 Section 90 	<p>a. Reworking/review of the cost report after audit</p> <p>b. Preparation and typing of all transmittal letters (NPR and Management Letter)</p> <p>c. Final review by the supervisor for approval</p> <p>d. Issuing the NPR</p>	<p>Workload 1 is Line 10a of the CASR IER, the number of cost reports settled.</p>

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26004	Cost Report Re-openings	Includes all work related to the reopening of a cost report. Reference: <ul style="list-style-type: none">• CMS Medicare Manual System Pub 100-06 Financial Management Chapter 8 Section 100	a. Review of the request for reopening b. Review documentation from the provider and determine if there is any change in the settlement c. If necessary, re-settle the re-opened cost report	Workload 1 is Line 13b of the CASR IER, the number of reopenings completed.
26005	Wage Index Review	Includes all activities related to wage index reviews. Reference: <ul style="list-style-type: none">• CMS Medicare Manual System Pub 100-06 Financial Management Chapter 8 Section 20.4	a. Follow the most recent transmittal/Change Request containing detail procedures for wage index review tasks	Workload 1 is a STAR system count taken from Screen C and is the number of hospital wage index reviews completed.
26010	STAR Activities	NOTE: This code is not included in the BPRs section for Audit because it is exclusively used by Mutual of Omaha to account for all work performed on the maintenance and enhancement of STAR Reference: <ul style="list-style-type: none">• MIM 13.4 STAR Procedures Manual	a. CMS will review and approve a yearly plan	

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26011	PRRB and Intermediary Hearings	<p>This code is now available to all FIs and includes all work performed on cost reports related to a provider's appeal.</p> <p>Reference:</p> <ul style="list-style-type: none"> • 42 CFR 405.1885 – 405.1889 • PRRB Instructions • PRM 15 Part 1 	<ul style="list-style-type: none"> a. Prepare position papers b. Participate in meetings with providers including work performed relating to administrative resolutions c. Participate in any mediations with PRRB staff and with providers d. Prepare for board hearing and interact with BCBS attorneys e. Testify before PRRB f. Prepare any evidence for CMS attorney advisor if Administrator intervention to overturn board decision is necessary 	<p>Workload 1 – cases closed – include all cases closed resulting from administrative resolutions, hearings, mediation, withdrawals, etc.</p> <p>Workload 2 – units closed – include all revised NPRs issued as a result of a PRRB or Intermediary appeal.</p>